BJPsych | The British Journal of Psychiatry (2013) 202, 383–386

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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IAPT is probably not cost-effective

The recent economic evaluation of an Improving Access to Psychological Therapies (IAPT) service conducted by Mukuria and colleagues[1] is a welcome addition to the evidence base pertaining to this programme. This was a non-randomised comparison but it appears that the authors have used appropriate methods to control for differences between areas. A casual reading of the abstract conclusion would lead one to assume that IAPT is likely to be cost-effective. Indeed, the cost per quality-adjusted life year (QALY) is below the upper threshold used by the National Institute for Health and Clinical Excellence (NICE), and below the lower threshold in a sensitivity analysis where the EQ-5D was used. However, the cost per QALY is somewhat misleading. The most useful results from this study are the cost-effectiveness acceptability curves shown in Fig. 2. Here it is revealed that at the NICE upper threshold of £30 000 per QALY, there is about a 38% likelihood that IAPT is cost-effective, increasing to just over 50% if the EQ-5D is used to generate QALYs. If the lower threshold is used, then there is even less chance that IAPT is cost-effective. The overall conclusion of this paper should be based on Fig. 2 and it should be that on the basis of this study IAPT was probably not cost-effective.

1 Mukuria C, Brazier J, Barkham M, Connell J, Hardy G, Hutten R, et al. Cost-effectiveness of an Improving Access to Psychological Therapies service. *Br J Psychiatry* 2013; **202**: 220–7.

Paul McCrone, Professor of Health Economics, King's College London, UK. Email: paul.mccrone@kcl.ac.uk

doi: 10.1192/bjp.202.5.383

Drop out from treatment in the World Mental Health Survey initiative

We read with interest the study by Wells *et al*[1] where the important issue of adherence to treatment services has been addressed. Although the study analysed the data generated from the robust methodology of the World Mental Health Survey, which is a landmark in the field of psychiatric epidemiology, it needs to address some of the conceptual issues of treatment adherence particularly relevant to the low-/lower-middle-income countries.

Long-term follow-up and regular treatment is mostly prevalent in high-income countries that have an organised mental healthcare service. In countries having lesser mental healthcare resources, such coordinated provision of treatment is lacking. When treatment is sought from general medical services, the patient is only provided symptomatic relief and neither the provider nor the client has any knowledge about long-term follow-up. Such lack of communication between them is mostly due to deficiency of mental health infrastructure in terms of either quality or quantity.[2] One may argue that traditional or non-conventional modes are the main treatment providers in such countries. But for them often the treatment proceeds on an 'as and when required' basis.[3] For spiritual and religious healers the client would often be attached to them in a special bond of faith or gratitude for generations, such as in the guru–chela relationship.[4] In such situations, a question such as 'Did you complete the full recommended course of treatment? Or did you stop before the [provider] wanted you to stop?' seems irrelevant. We propose that a little extra effort to standardise this question across different settings would have made the methodology of Wells *et al* more robust.

Slightly different definitions for mental health treatment drop out have been used in previous studies.[5,6] The authors have very rightly pointed out that this is one of the reasons for the differences between drop-out rates found in national surveys and corresponding subsamples of the present study. So, if such a 'slightly different definition' of drop out influences their rates in high-income countries where the determinants are less heterogeneous, we can obviously assume that its effect on the low-/lower-middle-income countries will be marked.

Although the authors have made elaborate attempts to find the predictors of drop out, they did not take into account many potentially relevant factors related to patient (e.g. stigma, functional impairment, satisfaction with treatment), professional (e.g. communication skills, clinical expertise) and service delivery (e.g. environmental obstacles). Apart from this, the fact that the centres in some countries were not representative of the whole population influenced generalisability of the study. Overall, this unique effort by the authors is praise-worthy and will go a long way in understanding the dynamics of treatment drop outs from a global perspective.

1 Wells JE, Browne MO, Aguilar-Gaxiola S, Al-Hamzawi A, Alonso J, Angermeyer MC, et al. Drop out from out-patient mental healthcare in the World Health Organization's World Mental Health Survey initiative. *Br J Psychiatry* 2013; **202**: 42–9.

2 World Health Organization. *Mental Health Atlas 2011*. WHO, 2011.

3 Chavan BS, Gupta N, Sidana A, Arun P, Jadhav S. *Community Mental Health in India*. Jaypee, 2012.

4 Neki JS. Guru-chela relationship: the possibility of a therapeutic paradigm. *Am J Orthopsychiatry* 1973; **43**: 755–66.

5 Edlund MJ, Wang PS, Berglund PA, Katz SJ, Lin E, Kessler RC. Dropping out of mental health treatment: patterns and predictors among epidemiological survey respondents in the United States and Ontario. *Am J Psychiatry* 2002; **159**: 845–51.

6 Wang J. Mental health treatment dropout and its correlates in a general population sample. *Med Care* 2007; **45**: 224–9.

Aniruddha Basu, Pt. Bagwat Dayal Sharma, Post Graduate Institute of Medical Sciences (PGIMS), Rohtak, Haryana, India. Email: draniruddhabasu@gmail.com; **Sidharth Arya**, Pt. Bagwat Dayal Sharma, Post Graduate Institute of Medical Sciences (PGIMS), Rohtak, Haryana, India

doi: 10.1192/bjp.202.5.383a

Author's reply: I thank Basu & Arya for their kind words about our paper and for their reaffirmation of the importance of addressing adherence to treatment. However, although they note that, 'In countries having lesser mental healthcare resources, such coordinated provision of treatment is lacking', our results (online

https://doi.org/10.1192/bjp.202.5.383 Published online by Cambridge University Press